Provider Participation Requirements (MHS)

Last Updated: 06/03/2022

Table of Contents

Provider Participation Requirements (MHS)

Updated: 1/19/2022

The Mental Health Services covered in this manual include: Community Mental Health Rehabilitative Services (CMHRS), Enhanced Behavioral Health Services (EBH), Mental Health Case Management (MHCM), and Treatment Foster Care Case Management. This chapter provides general provider participation requirements and provider specific requirements for CMHRS and MHCM. Provider specific requirements for EBH are located in Appendices to this manual.

Provider requirements for additional Behavioral Health services covered by the Department of Medical Assistance Services (DMAS) are located in the Addiction and Recovery Treatment Services (ARTS) Manual, Psychiatric Services Manual, and Residential Treatment Services Manual located on the DMAS website at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual.

Providers are responsible for adhering to all DMAS policies, this manual, available on the DMAS website portal, their provider contracts with the Medicaid Managed Care Organization (MCOs) and the fee for service (FFS) contractor, and related state and federal regulations.

Managed Care Enrolled Members (MHS)

Most individuals enrolled in the Medicaid program for Medicaid and FAMIS have their services furnished through DMAS contracted MCOs and their network of providers. All providers must check Medicaid member eligibility (Refer to Chapter 3) prior to rendering services to confirm whether an individual is enrolled in a Medicaid MCO and which particular MCO.

DMAS OFFERS A WEB-BASED INTERNET OPTION TO ACCESS INFORMATION REGARDING MEDICAID OR FAMIS MEMBER ELIGIBILITY AND MCO ENROLLMENT. PROVIDERS MUST REGISTER THROUGH THE VIRGINIA MEDICAID WEB PORTAL IN ORDER TO ACCESS THIS INFORMATION. THE VIRGINIA MEDICAID WEB PORTAL CAN BE ACCESSED BY GOING TO: WWW.VIRGINIAMEDICAID.DMAS.VIRGINIA.GOV. IF YOU HAVE ANY QUESTIONS REGARDING THE VIRGINIA MEDICAID WEB PORTAL, PLEASE CONTACT THE CONDUENT GOVERNMENT HEALTHCARE SOLUTIONS SUPPORT HELP DESK TOLL FREE, AT 1-866-352-0496 FROM 8:00 A.M. TO 5:00 P.M. MONDAY THROUGH

FRIDAY, EXCEPT HOLIDAYS. THE MEDICALL AUDIO RESPONSE SYSTEM PROVIDES SIMILAR INFORMATION AND CAN BE ACCESSED BY CALLING 1-800-884-9730 OR 1-800-772-9996. BOTH OPTIONS ARE AVAILABLE AT NO COST TO THE PROVIDER.

Even if the individual is enrolled with an MCO, some services may continue to be covered by Medicaid Fee-for-Service (FFS). Providers must follow the FFS rules in these instances where services are "carved-out." Refer to each managed care program's website for detailed information and the latest updates.

- Medallion 4.0:

  https://www.dmas.virginia.gov/for-providers/managed-care/medallion-40/

- Commonwealth Coordinated Care Plus (CCC Plus):

  https://www.dmas.virginia.gov/for-providers/managed-care/ccc-plus/

For providers to participate with one of the DMAS-contracted managed care organizations/programs, they must be credentialed by the MCO and contracted in the MCO's network. The credentialing process can take approximately three (3) months to complete. Providers of CMHRS, EBH and MHCM need to be credentialed with the MCO that an individual is enrolled in to provide these services to an individual enrolled in managed care.

Program of All-Inclusive Care for the Elderly (PACE)

Mental Health Services for individuals enrolled in PACE are provided by the individual's PACE Program. For additional details see https://www.dmas.virginia.gov/for-providers/long-term-care/programs-and-initiatives/program-of-all-inclusive-care/

BEHAVIORAL HEALTH FEE FOR SERVICE (FFS) CONTRACTOR

Magellan of Virginia currently serves as the Behavioral Health FFS contractor and is responsible for the management and direction of the fee for service (FFS) behavioral health benefits program under contract with DMAS. Magellan of Virginia is authorized to create,

manage, enroll, and train a FFS provider network; perform service authorization; adjudicate claims; process claims; gather and maintain data; reimburse providers; perform quality assessment and improvement; conduct member outreach and education; resolve member and provider issues; and perform utilization management including care coordination for the provision of Medicaid-covered behavioral health services. Magellan of Virginia's authority shall include entering into or terminating contracts with providers and imposing sanctions upon providers as described in any contract between a provider and Magellan of Virginia. DMAS shall retain authority for and oversight of Magellan of Virginia entity or entities.

Providers under contract or who have questions about credentialing/contracting process with Magellan of Virginia should consult Magellan's National Provider Handbook, the Magellan Virginia Provider Handbook or contact Magellan of Virginia at 800-424-4536 or VAProviderQuestions@MagellanHealth.com or visit the provider website at https://www.magellanprovider.com/MagellanProvider.

Magellan of Virginia is responsible for enrollment and credentialing of FFS behavioral health providers based upon DMAS regulatory requirements.

The Magellan of Virginia Call Center has a centralized contact number **(1-800-424-4046**) for Medicaid/FAMIS members and providers. The Call Center is located in Virginia and is available 24 hours a day, 365 days a year. Staff members include bilingual and multi-cultural representatives who speak English and Spanish. Interpreter services, TDD/TTY and relay services are available for individuals with a hearing impairment. The TDD number is 1-800-424-4048.

All calls related to the fee-for-service behavioral health services should go to the Magellan of Virginia Call Center. Magellan of Virginia staff members are available to assist callers with:

- service authorizations,
- clinical reviews,
- member eligibility status,
- referrals for services,
- provider network status,

- claims resolution,
- reconsiderations,
- grievances and,
- complaints

Noted below are two (2) concepts that should be reflected in all providers' service delivery practices.

1) RECOVERY AND RESILIENCY

DMAS encourages the provider network to integrate principles into their practices and service delivery operations including providing high quality, consumer-focused, recovery-based behavioral health services for individuals enrolled in Virginia Medicaid. The federal Substance Abuse and Mental Health Services Administration (SAMHSA) defines recovery as a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Recovery is built on access to evidence-based clinical treatment and recovery support services for all populations (https://www.samhsa.gov/recovery).

A person's recovery is built on his or her strengths, talents, coping abilities, resources, and inherent values. It is holistic, addresses the whole person and their community, and is supported by peers, friends, and family members. Because recovery is a highly individualized process, recovery services and supports must be flexible to ensure cultural relevancy.

Resilience refers to an individual's ability to cope with adversity and adapt to challenges or change. Resilience develops over time and gives an individual the capacity not only to cope with life's challenges but also to be better prepared for the next stressful situation. Optimism and the ability to remain hopeful are essential to resilience and the process of recovery.

A recovery focus is also a preventive approach that simultaneously supports building

resiliency, wellness, measureable recovery and quality of life.

2) CULTURAL AND LINGUISTIC COMPETENCIES

DMAS encourages providers to demonstrate an understanding and respect for each individual's health-related beliefs and cultural values through the establishment of policies, practices and allocation of resources that support culturally and linguistically appropriate services. Culture has a significant impact on how people of different backgrounds express themselves, seek help, cope with stress and develop social supports. It also affects every aspect of an individual's life, including how they experience, understand, and express, mental and emotional distress, illness and conditions.

Development of cultural and linguistic competency means that providers have the ability to value diversity, adapt to diverse populations, obtain any needed education and training in order to enhance cultural knowledge, work within values and beliefs that may be different from their own, and be capable of evolving over extended periods of time as cultures change.

Providers licensed by the Department of Behavioral Health and Developmental Services (DBHDS) should refer to DBHDS for guidance in this area.

Participating Provider (MHS)

A participating provider is an agency, program, or person that meets the standards and requirements set forth by the Department of Medical Assistance Services (DMAS) or its contractor and that has a current, signed contract and is successfully credentialed with DMAS or it contractor.

Medicaid Program Information (MHS)

Federal regulations governing program operations require Virginia Medicaid to supply program information to all providers. The current system for distributing this information is keyed to the provider number on the enrollment file, which means that each assigned provider receives program information. Providers enrolled at multiple locations or who are members of a group using one central office may receive multiple copies of manual-change notices, updates, and other publications sent by DMAS or its contractor unless the provider requests that publications not be mailed to them.

PROVIDER ENROLLMENT (MHS)

To be a network provider of behavioral health services to serve members in the Virginia Medicaid/FAMIS programs, providers must be credentialed and enrolled according to DMAS standards with the FFS contractor and/or a Medicaid MCO. Providers are subject to applicable licensing requirements. Additionally, any licensed practitioner joining a contracted group practice or a contracted organization adding a newly licensed location must also become credentialed with the FFS contractor and/or a Medicaid MCO prior to rendering services. Please contact the FFS contractor or the Medicaid MCOs for additional information.

All participating Medicaid providers are required to complete a new contract agreement as a result of any name change or change of ownership.

Upon completion of the enrollment process, a ten-digit Atypical Provider Identifier (API) will be assigned as the provider identification number for non-healthcare providers. Healthcare providers are required to submit their National Provider Identifier (NPI) number. The API or NPI number must be used on all claims and correspondence submitted to DMAS or its contractors.

DMAS is informing the provider community that NPIs may be disclosed to other Healthcare Entities pursuant to CMS guidance. The NPI Final Rule requires covered healthcare providers to disclose their NPIs to any entities that request the NPIs for use of the NPIs in HIPAA standard transactions. DMAS may share your NPI with other healthcare entities for the purpose of conducting healthcare transactions, including but not limited to Referring Provider NPIs and Prescribing Provider NPIs.

Participation Requirements (MHS)

All providers enrolled in the Virginia Medicaid Program must adhere to the conditions of participation outlined in their Participation Agreements/contracts, provider contracts, manuals, and related state and federal regulations. Behavioral Health providers approved for participation in the MCOs and FFS contractor provider network must perform the following activities as well as any others specified by DMAS:

- Immediately notify the MCOs and the FFS contractor in writing whenever there is

a change in the information that the provider previously submitted, including adding new services, new service locations or changes in licensure. For a change of address, notify the MCOs and the FFS contractor prior to the change and include the effective date of the change;

- Once a health care entity has been enrolled as a provider, it shall maintain, and update periodically as DMAS or its contactor require, a current Provider Enrollment Agreement for each Medicaid service that the provider offers.

- Assure freedom of choice to individuals in seeking medical care from any institution, pharmacy, or practitioner qualified to perform the service(s) required and participating in the Medicaid Program at the time the service is performed;

- Assure the individual's freedom to reject medical care and treatment;

- Comply with Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §§ 2000d through 2000d-4a), which requires that no person be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance on the grounds of race, color, or national origin;

- Provide services, goods, and supplies to individuals in full compliance with the requirements of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), which states that no otherwise qualified individual with a disability shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. The Act requires reasonable accommodations for certain persons with disabilities;

- Provide services and supplies to individuals of the same quality and in the same mode of delivery as provided to the general public;

- Charge DMAS or its contractor for the provision of services and supplies to individuals in amounts not to exceed the provider's usual and customary charges to the general public;

- Not require, as a precondition for admission, any period of private pay or a deposit from the individual or any other party;

- Accept as payment in full the amount reimbursed by DMAS or its contractor. 42 CFR § 447.15 provides that a "State Plan must provide that the Medicaid agency must limit participation in the Medicaid Program to providers who accept, as payment in full, the amount paid by the agency …." The provider should not attempt to collect from the individual or the individual's responsible relative(s) any amount that exceeds the usual Medicaid allowance for the service rendered. For example: If a third-party payer reimburses $5.00 of an $8.00 charge, and Medicaid's allowance is $5.00, the provider may not attempt to collect the $3.00 difference from Medicaid, the individual, a spouse, or a responsible relative. The provider may not charge DMAS, its contractor or an individual for broken or missed appointments;

- Accept assignment of Medicare benefits for eligible Medicaid enrolled individuals;

- Accept Medicaid payment from the first day of eligibility if the provider was aware that an application for Medicaid eligibility was pending at the time of admission;

- Reimburse the individual or any other party for any monies contributed toward the individual's care from the date of eligibility. The only exception is when an individual is spending down excess resources to meet eligibility requirements;

- Use DMAS or its contractor designated billing forms for submission of charges;

- Maintain and retain business and professional records that document fully and accurately the nature, scope, and details of the health care provided; In general,

such records must be retained for a period of at least five years from the date of service or as provided by applicable federal and state laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved. Providers who are contracted with managed care organizations must follow their contract requirements for record retention.

- Furnish to authorized state and federal personnel, in the form and manner requested, access to records and facilities;

- Disclose, as requested by DMAS or its contractor, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to Medicaid members;

- Hold information regarding Medicaid enrolled individuals confidential. A provider shall disclose information in his/her possession only when the information is used in conjunction with a claim for health benefits or the data is necessary for the functioning of the state agency. DMAS shall not disclose medical information to the public;

- Providers of all CMHRS are required to adhere to DMAS marketing requirements. Providers that DMAS determines violate these marketing requirements shall be terminated as a Medicaid provider; and

- Providers must comply with the Code of Virginia (§ 54.1-2400.4) mandate to inform their clients of the right to report misconduct to the Department of Health Professions.

ADVERSE OUTCOMES (MHS)

Mental Health Services providers must notify the FFS contractor or the appropriate MCO of member adverse outcomes or critical incidents within one business day following knowledge of the incident. Providers must follow notification or reporting processes required by

applicable Local, State and Federal regulatory bodies or contracts with the MCOs and FFS contractor.

PROVIDER RESPONSIBILITES TO IDENTIFY EXCLUDED INDIVIDUALS AND ENTITIES (MHS)

In order to comply with federal regulations and Virginia Medicaid policy, providers are required to ensure that Medicaid is not paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities.

Medicaid payments cannot be made for items or services furnished, ordered, or prescribed by an excluded physician or other authorized person when the person or entity furnishing the services either knew or should have known about the exclusion. This provision applies even when the Medicaid payment itself is made to another provider, practitioner, or supplier that is not excluded, yet affiliated with an excluded provider. A provider who employs or contracts with an excluded person or entity for the provision of items or services reimbursable by Medicaid may be subject to overpayment liability as well as civil monetary penalties.

All providers are required to take the following three steps to ensure Federal and State program integrity:

1. Screen all new and existing employees and contractors to determine whether any of them have been excluded.

2. Search the HHS-OIG List of Excluded Individuals and Entities (LEIE) website monthly by name for employees, contractors and/or entities to validate their eligibility for Federal programs. See below for information on how to search the LEIE database.

3. Immediately report to DMAS any exclusion information discovered. Such information should be sent in writing and should include the person or business name, provider identification number (if applicable), and what, if any, action has been taken to date. The information should be sent to:

DMAS

Attn: Program Integrity/Exclusions

600 E. Broad St, Ste. 1300

Richmond, VA 23219

-or-

E-mailed to: providerexclusions@dmas.virginia.gov

Provider Qualifications (MHS)

To qualify as a provider of Medicaid mental health services, the provider of the services must meet the following criteria:

The provider must have the administrative and financial management capacity to meet state and federal requirements; and

The provider must have the ability to document and maintain individual case records in accordance with state and federal requirements.

In addition to the criteria stated above, a provider must meet the following requirements:

Provider Credentials for Mental Health Services Staff:

Mental health providers are responsible for ensuring that employed or contracted staff meet the service-specific staff requirements of all services rendered by the service provider including licensure or registration, as appropriate, by a health regulatory board at the Department of Health Professions (DHP). Staff shall only work within the scope of practice as defined by the applicable DHP health regulatory board. All provider sites must be credentialed by the DMAS contractor, licensed by DBHDS as applicable and in compliance with all requirements as defined in DMAS regulations.

"**Certified substance abuse counseling assistant**" or **"CSAC-A"** means the same as that term is defined in 12VAC30-130-5020.

Certified substance abuse counselor" or **"CSAC"** means the same as that term is defined in 12VAC30-130-5020.

"**CSAC supervisee"** means the same as that term is defined in 12VAC30-130-5020.

"Certified pre-screener" means an employee of the local community services board or behavioral health authority, or its designee, who is skilled in the assessment and treatment of mental illness and has completed a certification program approved by DBHDS.

"Credentialed addiction treatment professional" or **"CATP**" means the same as defined in 12VAC30-130-5020, an individual licensed or registered with the appropriate board in the following roles: (i) an addiction-credentialed physician or physician with experience or training in addiction medicine; (ii) physician extenders with experience or training in addiction medicine; (iii) a licensed psychiatrist; (iv) a licensed clinical psychologist; (v) a licensed clinical social worker; (vi) a licensed professional counselor; (vii) a certified psychiatric clinical nurse specialist; (viii) a licensed psychiatric nurse practitioner; (ix) a licensed marriage and family therapist; (x) a licensed substance abuse treatment practitioner; (xi) a resident who is under the supervision of a licensed professional counselor (18VAC115-20-10), licensed marriage and family therapist (18VAC115-50-10), or licensed substance abuse treatment practitioner (18VAC115-60-10) and is registered with the Virginia Board of Counseling; (xii) a resident in psychology who is under supervision of a licensed clinical psychologist and is registered with the Virginia Board of Psychology (18VAC125-20-10); or (xiii) a supervisee in social work who is under the supervision of a licensed clinical social worker and is registered with the Virginia Board of Social Work (18VAC140-20-10).

"Licensed assistant behavior analyst" or **"LABA"** means an individual who is licensed as an Assistant Behavior Analyst by the Virginia Board of Medicine as defined in 18VAC85-150-10 et seq.

"Licensed behavior analyst" or **"LBA"** means an individual who is licensed as a Behavior Analyst by the Virginia Board of Medicine as defined in 18VAC85-150-10 et seq.

"Licensed mental health professional" or **"LMHP"** means the same as defined in 12VAC35-105-20.

"LMHP-resident" or **"LMHP-R"** means the same as "resident" as defined in (i)

18VAC115-20-10 for licensed professional counselors; (ii) 18VAC115-50-10 for licensed marriage and family therapists; or (iii) 18VAC115-60-10 for licensed substance abuse treatment practitioners. An LMHP-resident shall be in continuous compliance with the regulatory requirements of the applicable counseling profession for supervised practice and shall not perform the functions of the LMHP-R or be considered a "resident" until the supervision for specific clinical duties at a specific site has been preapproved in writing by the Virginia Board of Counseling. For purposes of Medicaid reimbursement to their supervisors for services provided by such residents, they shall use the title "Resident" in connection with the applicable profession after their signatures to indicate such status.

"LMHP-resident in psychology" or **"LMHP-RP"** means the same as an individual in a residency, as that term is defined in 18VAC125-20-10, program for clinical psychologists. An LMHP-resident in psychology shall be in continuous compliance with the regulatory requirements for supervised experience as found in 18VAC125-20-65 and shall not perform the functions of the LMHP-RP or be considered a "resident" until the supervision for specific clinical duties at a specific site has been preapproved in writing by the Virginia Board of Psychology. For purposes of Medicaid reimbursement by supervisors for services provided by such residents, they shall use the title "Resident in Psychology" after their signatures to indicate such status.

"LMHP-supervisee in social work," "LMHP-supervisee" or **"LMHP-S"** means the same as "supervisee" as defined in 18VAC140-20-10 for licensed clinical social workers. An LMHP-supervisee in social work shall be in continuous compliance with the regulatory requirements for supervised practice as found in 18VAC140-20-50 and shall not perform the functions of the LMHP-S or be considered a "supervisee" until the supervision for specific clinical duties at a specific site is preapproved in writing by the Virginia Board of Social Work. For purposes of Medicaid reimbursement to their supervisors for services provided by supervisees, these persons shall use the title "Supervisee in Social Work" after their signatures to indicate such status.

“Registered Peer Recovery Specialist (PRS)” means the same as the term is defined in § 54.1-2400.1 of the Code of Virginia.

"Qualified mental health professional-adult" or "QMHP-A" the same as the term is defined in § 54.1-3500 of the Code of Virginia..

"Qualified mental health professional-child" or **"QMHP-C”** means the same as the term is defined in § 54.1-3500 of the Code of Virginia. A QMHP-C may only provide services to individuals under the age of 22.

"Qualified mental health professional-eligible" or **"QMHP-E"** means the same as the term "qualified mental health professional-trainee" as defined in § 54.1-3500 of the Code of Virginia.

The QMHP-E staff must have at least one hour of supervision per week by a LMHP, LMHP-R, LMHP-S or LMHP-RP which must be documented in the employee file. Evidence of compliance with the QMHP-E criteria must be in the staff file.

"Qualified paraprofessional in mental health" or **"QPPMH"** means the same as the term is defined in 12VAC35-105-20.

Training and Supervision Requirements for QPPMHs

According to DBHDS regulations 12VAC35-105-20, individuals can complete 90 hours of classroom training to meet the QPPMH training qualification. An outline for a DMAS and DBHDS approved QPPMH training is included as an exhibit to this chapter.

Supervision of a QPPMH by a QMHP-C, QMHP-A, or LMHP, LMHP-R, LMHP-RP or LMHP-S is demonstrated by a review of progress notes, the individual's progress toward achieving ISP goals and objectives, and recommendations for change based on the individual's status. Supervision must occur monthly. Documentation that supervision occurred must be in the individual's clinical record and signed by the supervisor. Individual, group, or a combination of individual and group supervision is acceptable.

Department of Health Professions Registration

For reimbursement purposes, DMAS requires QMHP-A, QMHP-C and QMHP-Trainee (QMHP-E) staff to be registered with the Board of Counseling. Applicants may apply for QMHP registration by submitting an online application, fee and supplemental documentation with the Board of Counseling. For more information please visit the Board

of Counseling website:

https://www.dhp.virginia.gov/counseling/counseling_QMHP.htm

Effective January 1, 2019, DMAS and its contractors will deny reimbursement for services rendered by QMHP-A, QMHP-C and QMHP-Trainee (QMHP-E) staff who are not registered with the Board of Counseling.

Variance for Staff Working with Adults and Children

Effective 1/1/2019, all QMHP staff must be registered with the Board of Counseling. DMAS no longer recognizes variance staff who have not registered with the Board of Counseling as approved providers of these services.

Provider Requirements for Mental Health Service Agencies

Payments shall not be permitted to health care entities that either hold provisional DBHDS licenses or are not credentialed for each service site with the FFS contractor or Medicaid-contracted MCO prior to rendering that service.

Providers shall maintain documentation to establish that services are rendered by individuals with appropriate qualifications and credentials, including proof of licensure or registration through DHP if applicable. QMHPs shall adhere to all Virginia Board of Counseling regulations in accordance with 18VAC115-80-10 et. seq. QMHP-Es shall maintain documentation of supervision and of progress toward the requirements for DHP registration as a QMHP-C or progress toward the requirements for DHP registration as a QMHP-A.

Providers shall also adhere to DBHDS licensing requirements as defined in 12VAC35-105. The following licenses are consistent with DBHDS licensing regulations. All mental health providers must be in compliance with DBHDS licensing requirements including staffing requirements related to supervision (12VAC 35-105-590) and must have either a full, annual, triennial, or conditional license.

- For Applied Behavior Analysis (ABA) provider requirements, please refer to the Intensive Community Support – Youth Appendix of this manual.

- Intensive In-Home Services providers for children and adolescents must be licensed as a provider of Intensive In-Home Services (05-001) by DBHDS. All programs must have a LMHP who is responsible for the clinical oversight of the program. IIH services may only be rendered by an LMHP, LMHP-S, LMHP-R, LMHP-RP; or a QMHP-C or QMHP-E under the supervision of an LMHP, LMHP-R, LMHP-RP or LMHP-S.

- For Mental Health Intensive Outpatient (MH-IOP) provider requirements, please refer to the Intensive Clinic Based Support Appendix of this manual.

- Therapeutic Day Treatment (TDT) providers for children and adolescents must be licensed as a provider of Therapeutic Afterschool MH Service (02-014) and/or Therapeutic Day Treatment Service for Children and Adolescents (02-029) by DBHDS. Providers must have a non-school based TDT license with DBHDS to provide non-school based TDT. The minimum staff-to-youth ratio shall ensure that adequate staff is available to meet the needs of the youth identified on the Individualized Service Plan (ISP); TDT services may only be rendered by an LMHP, LMHP-S, LMHP-R, or LMHP-RP; or a QMHP-C or a QMHP-E under the supervision of an LMHP, LMHP-R, LMHP-RP or LMHP-S.

- For Mental Health Partial Hospitalization Program (MH-PHP) provider requirements, please refer to the Intensive Clinic Based Support Appendix of this manual.

- Psychosocial Rehabilitation providers must be licensed as a provider of Psychosocial Rehabilitation by DBHDS; Psychosocial Rehabilitation services may be provided by an LMHP, LMHP-S, LMHP-R, LMHP-RP, QMHP-A, QMHP-C, QMHP-E, or a QPPMH under the supervision of a QMHP-A, a QMHP-C, a QMHP-E, or an LMHP, LMHP-S, LMHP-R, or LMHP-RP.

- For Mobile Crisis Response, Community Stabilization, 23-Hour Crisis

Stabilization, and Residential Crisis Stabilization Unit provider requirements, please refer to the Comprehensive Crisis Services Appendix of this Manual.

- For Assertive Community Treatment provider requirements, please refer to the Intensive Community Support Appendix of this manual.

- Mental Health Skill-building Services providers must be licensed by DBHDS as a provider of Mental Health Community Support services. Mental Health Skill-Building services shall be provided by an LMHP, LMHP-S, LMHP-R, LMHP-RP, QMHP-A, QMHP-C, QMHP-E or QPPMH under the supervision of a QMHP-A, a QMHP-C, a QMHP-E, or an LMHP, LMHP-S, LMHP-R, or LMHP-RP.

- For Multisystemic Therapy (MST) and Functional Family Therapy (FFT) provider requirements please refer to the Intensive Community Support – Youth Appendix of this manual.

Please note per 12VAC35-105:

- DBHDS requires the supervision of services that are intensive and clinical in nature such as IIH or TDT, must be provided by a LMHP or LMHP-S, LMHP-R, or LMHP-RP.

- DBHDS requires the supervision of services that are supportive in nature such as psychosocial rehabilitation or MHSS shall be provided by a LMHP, LMHP-S, LMHP-R, LMHP-RP or QMHP-A.

Mental Health Case Management

There shall be no restriction on an individual's free choice of case management providers or other mental health or medical services providers. The mental health case management provider must be a Community Services Board member and licensed by DBHDS.

To qualify as a provider of services through DMAS for Mental Health Case Management for adults with serious mental illness and children and adolescents with serious emotional disturbance, the provider must meet the following criteria:

- The provider must have the administrative and financial management capacity to meet state and federal requirements;
- The provider must have the ability to document and maintain individual case records in accordance with state and federal requirements;
- The services shall be in accordance with the *Virginia Comprehensive State Plan for Behavioral Health and Developmental Services*; and
- The provider must be licensed as a provider of Case Management Services by DBHDS.

Providers may bill Medicaid for mental health case management only when the services are provided by qualified mental health case managers. Persons providing case management services must have knowledge of:

- Services, systems, and programs available in the community including primary health care, support services, eligibility criteria and intake processes, generic community resources, and mental health, developmental disability, and substance abuse treatment programs;
- The nature of serious mental illness, developmental disability, and substance abuse depending on the population served, including clinical and developmental issues;
- Different types of assessments, including functional assessments, and their uses in service planning;
- Treatment modalities and intervention techniques, such as behavior management, independent living skills training, supportive counseling, family education, crisis intervention, discharge planning, and service coordination;
- The service planning process and major components of a service plan;
- The use of medications in the care or treatment of the population served; and
- All applicable federal and state laws, regulations, and local ordinances.

Persons providing case management services must have skills in:

- Identifying and documenting an individual's needs for resources, services, and other supports;
- Using information from assessments, evaluations, observation, and interviews to develop Individual Service Plans;
- Identifying services and resources within the community and establishing service systems to meet the individual's needs and documenting how resources, services, and natural supports, such as family, can be utilized to achieve an individual's personal habilitative, rehabilitative, and life goals; and
- Coordinating the provision of services by public and private providers.

Persons providing case management services must have abilities to:

- Work with team members, maintaining effective inter- and intra-agency working relationships;
- Work independently, performing position duties under general supervision; and
- Engage and sustain ongoing relationships with individuals receiving services.

The provider must be a DBHDS-licensed case management provider, and case management must be provided by a qualified mental health case manager as defined above. The individual providing case management services is not required to be a member of an organizational unit that provides only case management. The case manager who is not a member of an organized case management unit must possess a job description that describes case management activities as job duties, must provide services as defined for case management, and must comply with service expectations and documentation requirements as required for organized case management units.

Treatment Foster Care Case Management

Treatment Foster Care Case Management shall be provided by child placing agencies with treatment foster care programs that are licensed or certified by the Virginia Department of Social Services (DSS) to be in compliance with DMAS and meet the provider qualifications for treatment foster care set forth in this manual, the FFS contractor provider contract and policies, and state and federal regulations.

Providers may bill Medicaid for case management for individuals in treatment foster care

only when the services are provided by qualified treatment foster care case managers. The treatment foster care case manager must meet, at a minimum, the qualifications specified by DMAS.

Minimum Standards for Treatment Foster Care Case Managers

- A Ph.D. or master's degree in social work from a college or university accredited by the Council on Social Work Education or in a field related to social work such as sociology, psychology, education, or counseling, with a student placement in providing casework services to children and families. One year of experience in providing casework services to children and families may be substituted for a student placement; or

- A baccalaureate degree in social work or a field related to social work including sociology, psychology, education, or counseling and one year of experience in providing casework services to children and families; or

- A baccalaureate degree in any field plus two years' experience in providing casework services to children and families.

PROVIDER SCREENING REQUIREMENTS (MHS)

All providers must now undergo a federally mandated comprehensive screening before their application for participation is approved by DMAS. Screening is also performed on a monthly basis for any provider who participates with Virginia Medicaid. A full screening is also conducted at time of revalidation, in which every provider will be required to revalidate at least every five (5) years.

The required screening measures are in response to directives in the standards established by Section 6401(a) of the Affordable Care Act in which CMS requires all state Medicaid agencies to implement the provider enrollment and screening provisions of the Affordable Care Act (42 CFR 455 Subpart E). These regulations were published in the Federal Register, Vol. 76, February 2, 2011, and were effective March 25, 2011. The required screening measures vary based on a federally mandated categorical risk level. Providers categorical risk levels are defined as "limited", "moderate" or "high". Please refer to the *Provider Risk Attachment* table at the end of this chapter (See Exhibits section) for a complete mapping of the provider risk categories and application fee

requirements by provider class type.

Limited Risk Screening Requirements

The following screening requirements will apply to limited risk providers: (1) Verification that a provider or supplier meets any applicable Federal regulations, or State requirements for the provider or supplier type prior to making an enrollment determination; (2) Verification that a provider or supplier meets applicable licensure requirements; and (3) federal and state database checks on a pre- and post-enrollment basis to ensure that providers and suppliers continue to meet the enrollment criteria for their provider/supplier type and that they are not excluded from providing services in federally funded programs.

Moderate Risk Screening Requirements

The following screening requirements will apply to moderate risk providers: Unannounced pre-and/or post-enrollment site visits in addition to those screening requirements applicable to the limited risk provider category listed above. The screening requirements listed in this section are to be performed at the time of initial enrollment and at the time of revalidation, which is at least every 5 years.

High Risk Screening Requirements

In addition to those screening requirements applicable to the limited and moderate risk provider categories listed above, providers in the high risk category may be required to undergo criminal background check(s) and submission of fingerprints. These requirements apply to owners, authorized or delegated officials or managing employees of any provider or supplier assigned to the “high” level of screening. At this time, DMAS is awaiting guidance from CMS on the requirements of criminal background checks and finger prints. All other screening requirements excluding criminal background checks and finger prints are required at this time.

Application Fees

All newly enrolling (including new locations), re-enrolling, and reactivating institutional providers are required to pay an application fee. If a provider class type is required to pay an application fee, it will be outlined in the Virginia Medicaid web portal provider

enrollment paper applications, online enrollment tool, and revalidation process. **The application fee requirements are also outlined in Appendix section of this provider manual.**

The Centers for Medicare and Medicaid Services (CMS) determine what the application fee is each year. This fee is not required to be paid to Virginia Medicaid if the provider has already paid the fee to another state Medicaid program or Medicare, or has been granted a hardship approval by Medicare.

Providers may submit a hardship exception request to CMS. CMS has 60 days in which to approve or disapprove a hardship exception request. If CMS does not approve the hardship request, then providers have 30 days from the date of the CMS notification to pay the application fee or the application for enrollment will be denied. An appeal of a hardship exception determination must be made to CMS as described in 42 CFR 424.514.

Out-of-State Provider Enrollment Requests

Providers that are located outside of the Virginia border and require a site visit as part of the Affordable Care Act are required to have their screening to include the passing of a site visit previously completed by CMS or their State's Medicaid program prior to enrollment in Virginia Medicaid. If your application is received prior to the completion of the site visit as required in the screening provisions of the Affordable Care Act (42 CFR 455 Subpart E) by the entities previously mentioned above, then the application will be rejected.

Revalidation Requirements (MHS)

All providers will be required to revalidate at least every 5 years. The revalidation of all existing providers will take place on an incremental basis and will be completed via the contracted MCO, the FFS contractor or DMAS.

Providers will receive written instructions from the MCOs, the FFS contractor or DMAS regarding the revalidation process, revalidation date and the provider screening requirements in the revalidation notice. If a provider is currently enrolled as a Medicare provider, the MCOs, FFS contractor and DMAS may rely on the enrollment and screening facilitated by CMS to satisfy the provider screening requirements.

ORDERING, REFERRING AND PRESCRIBING (ORP) PROVIDERS

Code of Federal Regulations 455:410(b) states that State Medicaid agencies must require all ordering or referring physicians or other professionals providing services under the State plan or under a waiver of the plan to be enrolled as participating providers.

The ACA requires ordering, referring, and prescribing providers to enroll only to meet new ACA program integrity requirements designed to ensure all orders, prescriptions or referrals for items or services for Medicaid beneficiaries originate from appropriately licensed practitioners who have not been excluded from Medicare or Medicaid. The only exception to this requirement is if a physician is ordering or referring services for a Medicaid beneficiary in a risk-based managed care plan, the provider enrollment requirements are not applicable to that ordering or referring physician.

If a provider does not participate with Virginia Medicaid currently but may order, refer or prescribe to Medicaid members they must now be enrolled to ensure claims will be paid to the servicing provider who is billing for the service.

As a servicing provider, it is essential to include the National Provider Identifier (NPI) of any ORP on all claims to ensure the timely adjudication of claims.

Please go to Chapter V of this provider manual to review the new billing procedures related to the implementation of these new screening requirements.

REQUIREMENTS OF SECTION 504 OF THE REHABILITATION ACT (MHS)

Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), provides that no individual with a disability shall, solely by reason of the disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal assistance. As a condition of participation, each Medicaid provider has the responsibility for making provisions for individuals with disabilities in the provider's programs or activities.

As an agent of the federal government in the distribution of funds, DMAS is responsible for monitoring the compliance of individual providers. The provider's submission of the claim indicates their assertion of compliance with the Rehabilitation Act.

In the event a discrimination complaint is lodged, DMAS is required to provide to the Office of Civil Rights (OCR) any evidence regarding compliance with these requirements.

UTILIZATION OF INSURANCE BENEFITS (MHS)

The Virginia Medical Assistance Program is a “last pay” program. Benefits available under Medical assistance shall be reduced to the extent that they are available through other federal, state, or local programs, other insurance, or third party liability. Health, hospital, Workers’ Compensation, or accident insurance benefits shall be used to the fullest extent in meeting the medical needs of the covered individual. Supplementation of available benefits shall be as follows:

Title XVIII (Medicare) - Virginia Medicaid will pay the amount of any deductible or co-insurance for covered health care benefits under Title XVIII of the Social Security Act for all eligible individuals covered by Medicare and Medicaid.

Workers’ Compensation - No Medicaid Program payments shall be made for an individual covered by Workers’ Compensation.

Other Health Insurance - When an individual has other health insurance (such as CHAMPUS/TRICARE, Blue Cross-Blue Shield, or Medicare), Medicaid requires that these benefits be used first. Supplementation shall be made by the Medicaid Program when necessary, but the combined total payment from all insurance shall not exceed the amount payable under Medicaid had there been no other insurance.

Liability Insurance for Accidental Injuries - DMAS will seek repayment from any settlements or judgments in favor of Medicaid enrolled individuals who receive medical care as the result of the negligence of another. If an individual is treated as the result of an accident and DMAS is billed for this

treatment, Medicaid should be notified promptly so action can be initiated by Medicaid to establish any lien that may exist under § 8.01-66.9 of the Code of Virginia. In liability cases, providers may choose to bill the third-party carrier or file a lien in lieu of billing Medicaid.

If there is an accident in which there is a possibility of third-party liability or if the individual reports a third-party responsibility (other than those cited on his or her Medical Assistance Identification Card), and whether or not Medicaid is billed by the provider for rendered services related to the accident, the provider must forward the DMAS-1000 form to the attention of the Third Party Liability Unit, DMAS, 600 East Broad Street, Richmond, Virginia 23219. (To obtain a copy of this form, see the "Replenishment of Billing Materials" section in Chapter V of this manual.)

Use of Rubber Stamps For Physician Documentation (MHS)

For Medicaid purposes, a required physician signature may include signatures, written initials, computer entries, or rubber stamps initialed by the physician. However, these methods do not preclude other requirements that are not for Medicaid purposes. For more complete information, see the *Physician Manual* issued by DMAS and review Chapter VI in this manual for information on medical record documentation and retention for psychiatric services.

FRAUD (MHS)

Provider fraud is willful and intentional diversion, deceit, or misrepresentation of the truth by a provider or his or her agent to obtain or seek direct or indirect payment, gain, or items of value for services rendered or supposedly rendered to individuals enrolled in Medicaid. A provider participation agreement will be terminated or denied when a provider is found guilty of fraud.

Since payment of claims is made from both State and Federal funds, submission of false or fraudulent claims, statements, or documents or the concealment of a material fact may be prosecuted as a felony in either Federal or State Court. DMAS maintains records for identifying situations in which there is a question of fraud and refers appropriate cases to the Office of the Attorney General for Virginia, United States Attorney General, or the appropriate law enforcement agency.

Further information about fraudulent claims is available in Chapter V, "Billing Instructions," and Chapter VI, "Utilization Review and Control" of this manual.

Termination of Provider Participation (MHS)

DMAS, the MCOs or the FFS contractor may terminate a provider from participating upon thirty (30) days written notification prior to the effective date. Such action precludes further payment by DMAS, the MCOs or the FFS contractor for services provided to customers subsequent to the date specified in the termination notice.

A participating provider may terminate participation in Medicaid at any time; however, written notification must be provided to the contracted MCO, FFS contractor, the DMAS Director and Conduent – Provider Enrollment Services (PES) 30 days prior to the effective date. The addresses are:

Director

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

Virginia Medicaid - PES

PO Box 26803

Richmond, Virginia 23261-6803

Provider Termination or Enrollment Denial: A Provider has the right to appeal in any case in which a Medicaid agreement or contract is terminated or denied to a provider pursuant to Virginia Code §32.1-325 (D) and (E). The provider may appeal the decision in accordance with the Administrative Process Act (APA) (Virginia Code §2.2-4000 et seq.), the State Plan for Medical Assistance provided for in § 32.1-325 et seq. of the Code of Virginia and the DMAS appeal regulations at 12 VAC 30-20-500 et. seq. Such a request must be in writing and must be filed with the DMAS Appeals Division within 15 calendar days of the receipt of the notice of termination or denial. This only applies to provider contracts with DMAS for fee-for-service or the FFS contractor. Providers denied or terminated from a MCO network do not have appeal rights with DMAS.

Termination of a Provider Contract Upon Conviction of a Felony (MHS)

Section 32.1-325 D.2 of the Code of Virginia mandates that "Any such Medicaid agreement or contract shall terminate upon conviction of the provider of a felony." A provider convicted of a felony in Virginia or in any other of the 50 states must, within 30 days, notify DMAS or the BHSA of this conviction and relinquish the agreement. Reinstatement will be contingent upon provisions of state law.

Appeals of Adverse Actions

Definitions:

Administrative Dismissal – means:

1) A DMAS provider appeal dismissal that requires only the issuance of an informal appeal decision with appeal rights but does not require the submission of a case summary or any further informal appeal proceedings; or

2) The dismissal of a member appeal on various grounds, such as lack of a signed authorized representative form or the lack of a final adverse action from the MCO or other DMAS Contractor.

Adverse Action – means the termination, suspension, or reduction in covered benefits or the denial, in whole or in part, of payment for a service.

Adverse Benefit Determination – Pursuant to 42 C.F. R. § 438.400, means, in the case of an MCO, any of the following: (i) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; (ii) The reduction, suspension, or termination of a previously authorized service; (iii) The denial, in whole or in part, of payment for a service; (iv) The failure to provide services in a timely manner, as defined by the State; (v) The failure of an MCO to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances an appeals; (vi) For a resident of a rural area with only one MCO, the denial of a member's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network; (vii) The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities. The denial, in whole or in part, of payment for a service solely because the claim does not meet the definition of a "clean claim" at § 447.45(b) is not an adverse benefit determination.

Appeal – means:

1) A member appeal is:

a. For members enrolled in an MCO, in accordance with 42 C.F.R. § 438.400, defined as a request for review of an MCO's internal appeal decision to uphold the MCO's adverse benefit determination. For members, an appeal may only be requested after exhaustion of the MCO's one-step internal appeal process. Member appeals to DMAS will be conducted in accordance with regulations at 42 C.F.R.§§ 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370; or

b. For members receiving FFS services, defined as a request for review of a DMAS adverse action or DMAS Contractor's decision to uphold the Contractor's adverse action. If an internal appeal is required by the DMAS Contractor, an appeal to DMAS may only be requested after the Contractor's internal appeal process is exhausted. Member appeals to DMAS will be conducted in accordance with regulations at 42 C.F.R.§§ 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370; or

2) For services that have already been rendered, a provider appeal is:

a. A request made by an MCO's provider (in-network or out-of-network) to review the MCO's reconsideration decision in accordance with the statutes and regulations governing the Virginia Medicaid appeal process. After a provider exhausts the MCO's reconsideration process, Virginia Medicaid affords the provider the right to two administrative levels of appeal (informal appeal and formal appeal) in accordance with the Virginia Administrative Process Act at Code of Virginia § 2.2-4000 *et seq*. and Virginia Medicaid's provider appeal regulations at 12 VAC 30-20-500 *et seq*.; or

b. For FFS services, a request made by a provider to review DMAS' adverse action or the DMAS Contractor's reconsideration decision in accordance with the statutes and regulations governing the Virginia Medicaid appeal process. If an adverse action requires reconsideration before appealing to DMAS, the provider must exhaust the Contractor's reconsideration process, after which Virginia Medicaid affords the provider the right to two administrative levels of appeal (informal appeal and formal appeal) in accordance with the Virginia Administrative Process Act at Code of Virginia § 2.2-4000 *et seq*. and Virginia Medicaid's provider appeal regulations at 12 VAC 30-20-500 *et seq*.

Internal Appeal – means a request to the MCO or other DMAS Contractor by a member, a member's authorized representative or provider, acting on behalf of the member and with the member's written consent, for review of the MCO's adverse benefit determination or DMAS Contractor's adverse action. The internal appeal is the only level of appeal with the MCO or other DMAS Contractor and must be exhausted by a member or deemed exhausted according to 42 C.F.R. § 438.408(c)(3) before the member may initiate a State fair hearing.

Reconsideration – means a provider's request for review of an adverse action. The MCO's or DMAS Contractor's reconsideration decision is a pre-requisite to a provider filing an appeal to the DMAS Appeals Division.

State Fair Hearing – means the Department's *de novo* evidentiary hearing process for member

appeals. Any internal appeal decision rendered by the MCO or DMAS Contractor may be appealed by the member to the Department's Appeals Division. The Department conducts *de novo* evidentiary hearings in accordance with regulations at 42 C.F.R. § 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370.

Transmit – means to send by means of the United States mail, courier or other hand delivery, facsimile, electronic mail, or electronic submission.

PROVIDER APPEALS

Non-State Operated Provider

The following procedures will be available to all non-state operated providers when an adverse action is taken that affords appeal rights to providers.

If the provider chooses to exercise available appeal rights, a request for reconsideration must be submitted if the action involves a DMAS claim under the EAPG payment methodology or involves a ClaimCheck denial. The request for reconsideration and all supporting documentation must be submitted within 30 days of the receipt of written notification of the underpayment, overpayment, and/or denial to the attention of the Program Operations Division at the following address:

Program Operations Division

Department of Medical Assistance Services

600 East Broad Street,

Richmond, Virginia 23219

DMAS will review the documentation submitted and issue a written response to the provider's request for reconsideration. If the adverse decision is upheld, in whole or part, as a result of the reconsideration process, the provider may then appeal that decision to the DMAS Appeals Division, as set forth below.

Internal appeal rights with a managed care organization ("MCO") must also be exhausted prior to appealing to DMAS if the individual is enrolled with DMAS through a Virginia Medicaid MCO.

For services that have been rendered and applicable reconsideration or MCO internal appeal rights have been exhausted, providers have the right to appeal adverse actions to DMAS.

Provider appeals to DMAS will be conducted in accordance with the requirements set forth in the Code of Virginia § 2.2-4000 *et. seq.* and the Virginia Administrative Code 12 VAC 30-20-500 *et. seq.*

Provider appeals to DMAS must be submitted in writing and **within 30 calendar days** of the provider's receipt of the DMAS adverse action or final reconsideration/MCO internal appeal decision. However, provider appeals of a termination of the DMAS provider agreement that was based on the

provider's conviction of a felony must be appealed **within 15 calendar days** of the provider's receipt of the DMAS adverse action. The provider's notice of informal appeal is considered filed when it is date stamped by the DMAS Appeals Division. The notice must identify the issues from the action being appealed. Failure to file a written notice of informal appeal within the prescribed timeframe will result in an administrative dismissal of the appeal.

The appeal must be filed with the DMAS Appeals Division through one of the following methods:

- Through the Appeals Information Management System ("AIMS") at https://www.dmas.virginia.gov/appeals/. From there you can fill out an informal appeal request, submit documentation, and follow the process of your appeal.
- Through mail, email, or fax. You can download a Medicaid Provider Appeal Request form at https://www.dmas.virginia.gov/appeals/. You can use that form or a letter to file the informal appeal. The appeal request must identify the issues being appealed. The request can be submitted by:
    - Mail or delivery to: Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219;
    - Email to appeals@dmas.virginia.gov; or
    - Fax to (804) 452-5454.

The Department of Medical Assistance Services normal business hours are from 8:00 a.m. to 5:00 p.m. Eastern time. Any documentation or correspondence submitted to the DMAS Appeals Division after 5:00 p.m. will be date stamped on the next day the Department is officially open. Any document that is filed with the DMAS Appeals Division after 5:00 p.m. on the deadline date will be untimely.

Any provider appealing a DMAS informal appeal decision must file a written notice of formal appeal with the DMAS Appeals Division **within 30 calendar days** of the provider's receipt of the DMAS informal appeal decision. The notice of formal appeal must identify each adjustment, patient, service date, or other disputed matter that the provider is appealing. Failure to file a written notice of formal appeal within 30 calendar days of receipt of the informal appeal decision will result in dismissal of the appeal. The notice of appeal must be transmitted through the same methods listed above for informal appeals.

The provider may appeal the formal appeal decision to the appropriate circuit court in accordance with the APA at the Code of Virginia § 2.2-4025, *et. seq*. and the Rules of Court.

The provider may not bill the member for covered services that have been provided and subsequently denied by DMAS.

Repayment of Identified Overpayments

Pursuant to § 32.1-325.1 of the *Code of Virginia*, DMAS is required to collect identified overpayments. Repayment must be made upon demand unless a repayment schedule is agreed to by DMAS. When lump sum cash payment is not made, interest shall be added on the declining balance at the statutory

rate, pursuant to the *Code of Virginia*, § 32.1-313.1. Repayment and interest will not apply pending the administrative appeal. Repayment schedules must ensure full repayment within 12 months unless the provider demonstrates, to the satisfaction of DMAS, a financial hardship warranting extended repayment terms.

State-Operated Provider

The following procedures will be available to state-operated providers when DMAS takes adverse action which includes termination or suspension of the provider agreement or denial of payment for services rendered. State-operated provider means a provider of Medicaid services that is enrolled in the Medicaid program and operated by the Commonwealth of Virginia.

A state-operated provider has the right to request a reconsideration of any issue that would be otherwise administratively appealable under the State Plan by a non-state operated provider. This is the sole procedure available to state-operated providers.

The reconsideration process will consist of three phases: an informal review by the Division Director, a further review by the DMAS Agency Director, and a Secretarial review. First, the state-operated provider must submit to the appropriate DMAS Division Director written information specifying the nature of the dispute and the relief sought. This request must be received by DMAS within 30 calendar days after the provider receives a Notice of Program Reimbursement (NPR), notice of proposed action, findings letter, or other DMAS notice giving rise to a dispute. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought, the amount of the adjustment sought and the reason(s) for seeking the adjustment. The Division Director or his/her designee will review this information, requesting additional information as necessary. If either party so requests, an informal meeting may be arranged to discuss a resolution.

Any designee shall then recommend to the Division Director whether relief is appropriate in accordance with applicable laws and regulations. The Division Director shall consider any recommendation of his/her designee and render a decision.

The second step permits a state-operated provider to request, within 30 days after receipt of the Division Director's decision, that the DMAS Agency Director or his/her designee review the Decision of the Division Director. The DMAS Agency Director has the authority to take whatever measures he/she deems appropriate to resolve the dispute.

The third step, where the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider, permits the provider to request, within 30 days after receipt of the DMAS Agency Director's Decision, that the DMAS Agency Director refer the matter to the Secretary of Health and Human Resources and any other Cabinet Secretary, as appropriate. Any determination by such Secretary or Secretaries shall be final.

Member Appeals

Member Appeals (MCO)

Members, their attorneys, or their authorized representatives have the right to appeal adverse benefit determinations to the Department. However, the MCO's internal appeal process must be exhausted, or deemed exhausted (due to the failure of the MCO to adhere to the notice and timing requirements), prior to a member filing an appeal with the DMAS Appeals Division.

Any member, member's attorney, or member's authorized representative wishing to appeal an adverse benefit determination must first file an internal appeal with the MCO **within 60 calendar days** from the date on the notice of adverse benefit determination. The internal appeal request may be submitted orally or in writing. For individuals with special needs or who do not understand English, the appeal rights must be provided in such a manner as to make it understandable by the individual.

A member may request continuation of services during the MCO's internal appeal and DMAS' State fair hearing. If an appeal is filed before the effective date of the action or within 10 days of the date the notice of adverse benefit determination was mailed, services may continue during the appeal process. If the final resolution of the appeal upholds the MCO's action and services to the member were continued while the internal appeal or State fair hearing was pending, the MCO may recover the cost of the continuation of services from the member.

Member appeals to DMAS are conducted in accordance with 42 C.F.R. § 431 Subpart E and the Department's Client Appeals regulations at Virginia Administrative Code 12 VAC 30-110-10 through 12 VAC 30-110-370.

If a member is dissatisfied with the MCO's internal appeal decision, the member or member's authorized representative may appeal to DMAS. Standard appeals of the MCO's internal appeal decision may be requested orally or in writing to DMAS. Expedited appeals of the MCO's internal appeal decision may be filed by telephone or in writing. The appeal may be filed at any time after the MCO's appeal process is exhausted and extending through **120 days after receipt** of the MCO's appeal decision. Appeal requests may be sent to the Appeals Division through the following methods:

- Accessing AIMS through a secure website at https://vamedicaid.dmas.virginia.gov/. From here, a member or representative can fill out an appeal request, submit documentation, and follow the process of an appeal. AIMS will be available starting in Spring 2021.

- By downloading a Medicaid/FAMIS Appeal Request form from the internet at https://www.dmas.virginia.gov/ or by writing a letter. The appeal request must identify the issues being appealed. The form or letter can be submitted by:
    - Mail or delivery to Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219
    - Email to appeals@dmas.virginia.gov, or
    - Fax to (804) 452-5454.

The Department's State fair hearing decision may be appealed to the appropriate circuit court by the member in accordance with the Administrative Process Act at Va. Code § 2.2-4025, *et. seq*. and the Rules of Court.

Member Appeals (FFS)

The Code of Federal Regulations at 42 CFR §431, Subpart E, and the Virginia Administrative Code at 12 VAC 30-110-10 through 370, require that written notification be provided to individuals when DMAS or any of its contractors takes an action that affects the individual's receipt of services. Most adverse actions may be appealed by the Medicaid member or by an attorney or authorized representative on behalf of the member. Adverse actions include partial approvals, denials, reductions in service, suspensions, and terminations. Also, failure to act on a request for services within required timeframes may be appealed. For individuals who do not understand English, a translation of appeal rights that can be understood by the individual must be provided.

If an appeal is filed before the effective date of the action, or within 10 days of the date the notice of action was mailed, services may continue during the appeal process. However, if the adverse action is upheld by the hearing officer, the member will be expected to repay DMAS or the DMAS Contractor for all services received during the appeal period. For this reason, the member may choose not to receive continued services. The DMAS Contractor will be notified by DMAS to reinstate services if continuation of services is applicable. If coverage is continued or reinstated due to an appeal, DMAS or the DMAS Contractor may not terminate or reduce services until a decision is rendered by the hearing officer.

Appeals may be requested orally or in writing by the member, the member's attorney, or the member's authorized representative. Appeals filed orally or electronically must be received within 30 days of receipt of the notice of adverse action. Appeals sent by mail must be postmarked within 30 days of receipt of the notice of adverse action. Forms are available on the internet at www.dmas.virginia.gov or by calling (804) 371-8488. A copy of the notice or letter about the action should be included with the appeal request.

Appeal requests may be sent to the Appeals Division through the following methods:

- Accessing AIMS through a secure website at https://vamedicaid.dmas.virginia.gov/. From here a member or representative can fill out an appeal request, submit documentation, and follow the process of an appeal. AIMS will be available starting in Spring 2021.
- The appeal request form or letter and any additional documentation can be submitted by:
    - Mail or delivery to Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219
    - Email to appeals@dmas.virginia.gov, or
    - Fax to (804) 452-5454.